Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SHASHI MITTAL, MD
P.O. BOX 121589
ARLINGTON, TX 76012

Respondent Name

ARCH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-0041-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DD EXAMS."

Amount in Dispute: $35.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation into this matter has revealed that we are not the claims administrator for this claim."

Response Submitted by: Specialty Risk Services, 35 Tesla Way #100, Irvine, CA 92618

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 08, 2010	99456-W5-TC, 99456-W5-26, 99080-73	$35.00	$20.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated February 09, 2010
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. In the carrier response letter to MFDR, the respondent states that "Our investigation into this matter has revealed that we are not the claims administrator for this claim." The same respondent had already partially paid on this claim, therefore this is not supported. The Division review of this fee dispute will proceed according to applicable fee guidelines found in 28 Texas Administrative Code §134.204 and per the Texas Labor Code §408.0041 which states in (h)(1):

   (h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a) or (f).

2. The requestor rendered the DD exam as ordered by the Division. The provider billed the amount of $650.00 each for CPT code 99456-W5-TC for the technical component and 99456-W5-26 for the professional component of the MMI/IR examination. Review of the documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Documentation supports a Range of Motion (ROM) IR method on the right ankle (lower extremities) for a MAR of $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). Review of documentation supports that the Division ordered the examinations via the EES-14 form. The combined MAR for the MMI/IR examinations is $650.00. The MAR amount is split between professional and technical components per 28 Texas Administrative Code §134.204 which states in parts (j)(4)(C)(iv) and (v):

   (iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

   (v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

   Therefore, with the type of IR performed plus the MMI reimbursement, the MAR for CPT code 99456-W5-26 is $520.00 and the MAR for CPT code 99456-W5-TC is $130.00. Regarding CPT code 99080-73, 28 Texas Administrative Code §134.204 states in part (k) that reimbursement "shall include Division-required reports." Therefore, no separate reimbursement is recommended for this report charge.

3. According to the explanation of benefits and the Table of Disputed Services, respondent paid $280.00 for 99456-W5-26 and $350.00 for the 99456-W5-TC totaling $630.00. As the MAR is $650.00, the recommendation for additional payment is $20.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $20.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the additional amount of $20.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 03, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.